STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676388	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion at Creekwood	2100 Cannon Dr Mansfield, TX 76063

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish a system of records of receipt and dispositon of all controlled drugs in sufficient detail to enable an accurate reconciliation for 3 of (200 hall, 300 hall, and 400 hall) of 4 medication carts reviewed for pharmacy services. The facility failed to ensure proper storage and disposal of Resident #60's Tylenol#3-300 mg (controlled medication) by taping a narcotic medication and storing it in medication cart. The facility failed to ensure proper storage and disposal of Resident #68's hydrocodone 5-325mg (controlled medication) by taping a narcotic medication and storing it in medication cart. The facility failed to ensure proper disposal Resident #120's lorazepam 0.5mg (controlled medication) Resident discharged [DATE]. This failure could place residents at risk of drug diversion, medication error, and risk of pills contamination due to broken seals. Findings included: Resident #60 Review of Resident #60's Comprehensive MDS Assessment, dated [DATE], reflected Resident #60 was admitted on [DATE], he was a [AGE] year-old male, and had a BIMs score of 15 indicated he was cognitively intact. The resident had diagnoses which included Type 2 diabetes mellitus with foot ulcer (a serious, high-risk condition, affecting up to one-third of diabetics and potentially leading to infections, hospitalization, or amputation). Review of Resident #60's Comprehensive Care Plan, initiated [DATE], Edited: [DATE] reflected: Resident #60's is at risk for pain/discomfort r/t IMPAIRED MOBILITY, DIABETIC WOUND WITH OSTEOMYELITIS (a serious, often bacterial, infection of the bone or bone marrow, resulting in swelling, pain, and potentially bone destruction). Interventions included Administer medication as ordered, assess pain/discomfort every shift on a scale of 1-10. Review of Resident #60's active physician orders Dated:[DATE] reflected acetaminophen-codeine - Schedule III tablet (controlled medication); 300-30 mg; amt: 1 TABLET; oral Every 4 Hours - PRN Order start [DATE]. Observation on [DATE] at 9:14 AM, of the 400 Hall nurses' medication cart with RN C, revealed Resident #60's Tylenol #3-300mg had 4 broken seals on the blister pack secured with clear tape. The damaged blister packs had the pills still inside at the time the surveyor inspected the medication cart. During an interview on [DATE] at 9:17 AM, RN C stated she did not see Resident #60's Tylenol #3-300mg blister pack seals were broken during the count. She stated the nurses were responsible for checking the medication blister packs for broken seals during the count of narcotics at change of shift. She stated that the risk of a damaged blister would be potential for drug diversion and contamination of the medication. She stated discharged residents' medication should be removed from the medication cart as soon as the resident discharged . She stated the risk to the residents was medication error because a discharged resident medication could be accidentally administered to another resident. She stated she had been in service on medication storage. Resident #68 Review of Resident #68's Quarterly MDS Assessment, dated [DATE] reflected the resident was a [AGE] year-old male, had a BIMs score of 12 indicated he was moderately cognitively impaired. The resident had diagnoses which included Diabetes Mellitus. Review of Resident #68's Care Plan edited: [DATE] reflected: Resident #68 is incontinent of Bowel and Bladder. Intervention included Give pain meds PRN, monitor effectiveness. Monitor for complaints of verbal and non-verbal signs of pain during urination. Review (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of Resident #68's active physician orders Dated:[DATE] reflected hydrocodone 5-325mg amt:1 tablet; oral every 4-PRN. Observation on [DATE] at 9:13 AM, of the 200 Hall nurses' medication cart with RN D, revealed Resident #68's hydrocode 5-325mg had 2 broken blister seals on the blister pack. The damaged blister pack had the capsule still inside at the time the surveyor inspected the medication cart. During an interview on [DATE] at 9:15 AM, RN D stated she was unaware Resident #68's hydrocodone 5-325mg blister pack seal was broken. She stated the nurses were responsible for checking the medication blister packs for broken seals during the count of narcotics during the change of shift. She stated that the risk of a damaged blister would be potential for drug diversion and contamination of the medication. She stated she had been inserviced on medication storage. Resident #120 Review of Resident #120's Quarterly MDS Assessment, dated [DATE], reflected the resident#120 is a [AGE] year-old female. admission date [DATE] and discharged [DATE]. Section A Coded 13 indicated resident was deceased . Review of Resident #120's Comprehensive Care Plan, revealed no care plan problem goals, or intervention related to the medication. Resident#120 was discharged [DATE]. Review of Resident #120's physician orders reflected lorazepam - Schedule IV tablet (controlled medication); 0.5 mg; amt: 1 tablet; oral Special Instructions: One PO/SL q6 hours PRN anxiety/restlessness Every 6 Hours - PRN. Observation on [DATE] at 9:10 AM, of the 300 hall nurses' cart with RN B, indicated Resident # 120's Lorazepam 0.5mg (controlled medication) who had been discharged [DATE] was stored and available in the medication cart. During an interview on [DATE] at 9:12 AM, RN B stated Resident # 120's Lorazepam 0.5mg (controlled medication) should have been removed from the cart when she discharged . She stated the risk was a medication error because a discharged residents medication could be accidentally administered to another resident and potential for drug diversion. She stated she had been inserviced on medication storage. During an interview on [DATE] at 3:29 PM, the DON stated her expectation was that the nurses would not tape narcotics blister packs. She stated narcotics with broken seals should be wasted and witnessed by two nurses. She stated the discharged residents' medication should be removed from the medication cart as soon as the resident discharged . She stated having discharged residents' medication in the medication cart could lead to a medication error. She stated the pharmacy consultant audits the medication rooms and the medication carts monthly. She stated the risk to the residents of taping narcotics was contamination and medication error. She stated the nurses had been inserviced on medication storage. Review of the facility's policy Medication Storage Revised [DATE] reflected the following: Medications and biologic biologicals are stored safely securely and properly following manufacturer's recommendations or those of the suppliers in accordance with state and federal laws the facility will store all drugs and biological in locked compartments under proper temperature and other appropriate environmental controls to preserve the integrity.Once any medication or biologicals package is opened, the facility should follow manufacturers/suppliers' guidelines with respect to expiration dates of opened medications.All scheduled medications and other drugs subject to abuse are stored in a separate permanently of affixed area and are under double lock.Outdated contaminated and deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from the stocks pulled off according to procedures for medication distraction and reorder from the pharmacy replacements as needed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to ensure the accurate acquiring, receiving, dispensing, administering, and disposal of for 3 (hall 300, 400 hall, and 200 hall) of 4 medication carts reviewed for pharmacy services. The facility failed to ensure Resident #47's Trelegy elipta (a disposable, dry-powder inhaler) was dated after opening and before storage in the medication cart. The facility failed to ensure Resident #90's Breo elipta (in haler used to treat asthma) was dated after opening and before storage in the medication cart The facility failed to ensure of Resident #58's unopened Lantus SoloStar (disposable, prefilled, long-acting insulin) which required refrigeration per manufacturer's guidelines was observed stored unrefrigerated. These failures could place residents at risk of medication errors, reduced therapeutic effectiveness, unsafe administration and potential adverse outcome due to improper storage of medication.Findings included: Resident #47 Review of Resident #47's Quarterly MDS Assessment, dated 03/02/2026, reflected a [AGE] year-old female and had a BIMs score of 12 indicated moderate cognitive impairment. The resident had diagnoses which included Asthma, (a chronic, non-curable inflammatory lung disease causing airway obstruction, characterized by wheezing, chest tightness, coughing, and shortness of breath). Review of Resident #47's Comprehensive Care Plan, Edited: 04/06/2026 reflected: [NAME] is at risk for respiratory distress/SOB due to Dx of: COPD, ACUTE/CHRONIC RESP FAILURE Interventions included Administer medications as ordered. Monitor adverse reaction. Contact MD if noted. Review of Resident #47's active physician orders Dated 04/7/2026 reflected: Trelegy Ellipta blister with device(a disposable, dry-powder inhaler); 100-62.5-25 mcg; amt:1puff; inhalation Special Instructions: Rinse mouth with water after each use Once A Day start date 02/05/2026. Observation on 04/12/2026 at 9:10 AM, of the 300 Hall Nurses Cart with RN B revealed, Resident #47's Trelegy Ellipta did not have an opening date. During an interview on 04/12/2026 at 9:12 AM, RN B stated she was unaware Resident #47's Trelegy Ellipta labeled to expire 6 weeks after opening required to be dated after opening. She stated the nurses were responsible for ensuring all medication in the cart was dated. She stated that she had been inserviced on medication labeling and storage. Resident #90 Review of Resident #90's Quarterly MDS Assessment, dated 02/06/2026, reflected a [AGE] year-old female and had a BIMs score of 07 considered severe cognitive impairment. The resident had diagnoses which included Asthma (a chronic, non-curable inflammatory lung disease causing airway obstruction, characterized by wheezing, chest tightness, coughing, and shortness of breath). Review of Resident #90's Comprehensive Care Plan, Date Initiated: 04/02/2026 reflected Resident #90 is at risk for respiratory distress/SOB due to Dx of: COPD Interventions included Administer breathing treatments as ordered. Keep Nebulizer mask/tubing bagged when not in use. Review of Resident #90's active physician orders dated 04/7/2026 reflected: Breo Ellipta blister(a once-daily prescription maintenance inhaler used to treat asthma) with device; 200-25mcg/dose; amt: 1; inhalation Special Instructions: Rinse Mouth with water after each use Once A Day order start 04/02/2026. Observation on 04/13/2026 at 9:13 AM, of 200 hall nurses cart 200 Hall Nurses Cart with RN D revealed, Resident #90's Breo Ellipta had no opening date. During an interview on 04/13/2026 at 9:15 AM, RN D stated she was unaware Resident #90's Breo Ellipta labeled to expire 6 weeks after opening required to be dated after opening. She stated the nurses were responsible for ensuring medication in the cart was dated after opening. She stated the risk to the resident was medication error and someone could take the medication. She stated that she had been in serviced on medication labeling and storage. Resident #58 Review of Resident #58's Quarterly MDS Assessment, dated 03/20/2026, reflected a [AGE] year-old male and had a BIMs score of 07 considered severe cognitive impairment. The resident had diagnoses which (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included Diabetes Mellitus (a chronic metabolic disorder characterized by high blood sugar (glucose) due to inadequate insulin production). Review of Resident #58's Comprehensive Care Plan, Date Initiated reflected: Resident #58's is Immunodeficient r/t: Malnutrition risk. Interventions included: Administer meds as ordered. Review of Resident #58's active physician orders dated 04/7/2026 reflected: Lantus Solostar U-100 Insulin (insulin glargine) insulin pen; 100 unit/mL (3 mL);amt: 40 units; subcutaneous start order 03/17/2026. Review of the Lantus SoloStar Step-by-Step guide (www.Lantus.com) reflected, .HOW TO STORE YOUR UNOPENED LANTUS SOLOSTAR PEN .Before opening, store Lantus in the refrigerator (36 F to 46 F) . Observation on 04/12/2026 at 9:14 AM, of the 400 Hall Nurses Cart with RN C revealed, Resident #58's unopened Lantus which required refrigeration before opening per manufacturer's guidelines was observed stored unrefrigerated in the medication cart. During an interview on 04/12/2026 at 9:17 AM, RN C stated Resident #58's unopened Lantus should be stored in the refrigerator until it is opened and dated. She stated the nurses were responsible for ensuring all medication in the cart were dated after opening. She stated the risk to the resident was the insulin would loose it effectiveness when used to treat the residents blood sugar levels. She stated that she had been in serviced on medication labeling and storage. During an interview on 04/14/26 at 1:04 PM, the DON stated nurses were responsible for ensuring medication was dated after opening and medication that required refrigeration's like unopened insulin were refrigerated. She stated the ADON audited the medication carts weekly, then the pharmacy consultant checks the medication room, and the medication cart every month. She stated if medication were supposed to be refrigerated it should be refrigerated because the medication could lose its effectiveness. She stated that the nurses and medication aides had been in serviced on medication storage. Review of the facility's policy Medication Storage Revised 4/17/2024 reflected the following: .Medications and biologic biologicals are stored safely securely and properly following manufacturer's recommendations or those of the suppliers in accordance with state and federal laws the facility will store all drugs and biological in locked compartments under proper temperature and other appropriate environmental controls to preserve the integrity. Facility staff should monitor and record the temperature of refrigerator and freezer twice a day. The medication and biologicals supply is only accessible to licensed nursing personnel, pharmacy, pharmacy personnel or authorized staff members.Medication Refrigerators: 36 - 46-degree F or 2 - 8 Degree C.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen, in that: There was a box of dinner rolls that was opened and unsealed in the walk-in deep freezer. There was a bag of lettuce heads that was opened, unsealed, without a label and use-by date in the walk-in refrigerator. There was a bag of mixed salad greens that had been previously opened and partially used, wrapped in clear plastic wrapping without a label and use-by date in the walk-in refrigerator. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness.Findings included:1. Observation on 4/12/2026 at 9:22 AM, revealed there was a 11.25-lb box of dinner rolls on a shelf in the walk-in freezer. The dinner rolls were in the original packaging, a clear plastic bag inside of the box. The box was opened from the top and the plastic bag holding the rolls was open. A white sticker on the box read 4/7/2026.2. Observation on 4/12/2026 at 9:25 AM in the walk-in refrigerator revealed a clear plastic bag of lettuce heads stored unsealed without a use-by date on the packaging.3. Observation on 4/12/2026 at 9:26 AM in the walk-in refrigerator revealed a bag of mixed salad greens, previously opened and partially used, without a label or use-by date. The mixed salad greens were observed to be wrapped several times in clear plastic wrap. During an interview on 4/12/2026 at 9:29 AM, the Morning Cook, reported every morning she would check to ensure all food stored in the kitchen was labeled and dated. She observed the dinner rolls, lettuce heads, and mixed lettuce greens. She stated she would throw the food items away. She reported the risk posed to residents by undated and exposed food could cause cross contamination. During an interview on 4/14/2026 at 12:00 PM with the Dietary Manager, she reported she was made aware of the food items in the kitchen that were exposed to air and not dated. She reported that food should have been closed and labeled/dated. She reported the Morning [NAME] threw away the dinner rolls after surveyor identified. She reported the risk to residents was potential freezer burn and contaminated food. She reported that foodborne illness is a potential risk. She reported she conducted an in-service that same day with all kitchen staff on food safety, storage, and labeling. Record review of the facility policy titled Food Safety in Receiving and Storage, dated 10/15/2025, reflected in part: tightly reseal opened packages to prevent contamination or place food in covered containers. Containers holding food or food ingredients that are removed from their original packages are identified with the common name of the food.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for one of six residents (Resident #79) reviewed for resident rights. The facility did not ensure LVN A knocked on the door before entering Resident #79's room or announced herself. These failures could place residents at an increased risk of diminished quality of life.Findings included: Resident #79 Record review of Resident #79's Quarterly MDS Assessment, dated 03/07/2026, reflected a [AGE] year-old female, originally admitted to the facility on [DATE]. The resident had a BIMS score of 9 which indicated moderate cognitive impairment. Diagnoses included: Unspecified dementia (severe decrease in memory and intellectual functioning that can occur in the later stages of Parkinson's), Type II Diabetes (a condition where the body can't properly use sugar for energy, leading to high blood sugar and possible complications), and Hypertension (blood pressure is consistently too high, which can strain the heart and blood vessels). Resident #79 required extensive assistance for bed mobility, transfer, and toilet use. Review of Resident #79's Comprehensive Care Plan, dated 2/27/2026, reflected Resident #79 required the use of side rails (positioning bar) for turning and repositioning with an intervention of keeping the call light within reach. The plan also identified the resident as a fall risk with an intervention of keeping the call light within reach at all times. Resident #79's care plan identified she had impaired visual function with an intervention stating staff would announce self by name, position, and call resident by her name. During an observation and interview on 4/12/2026 at 10:13 AM, Resident #79 reported her incontinent brief was wet and needed changed. She reported she had not told anyone because she could not find her call button. Her call button was observed on a nightstand. Resident #79 stated she was not sure who put the call button there and could not reach it. During an interview with LVN A on 4/12/2026 at 10:17 AM, LVN A was told Resident #79 expressed she needed to be changed and could not call for assistance because her call light was out of reach. LVN A stated she would send a CNA to help the resident. LVN A was asked to accompany surveyor to Resident #79's room to see her call light placement. LVN A walked into the room and placed the call light on the resident's stomach and walked out. LVN A was observed walking into the resident's room without knocking or announcing herself to the resident. LVN A did not say anything to the resident. LVN A stated staff are required to knock on every resident's door and say their name so that the resident would know who you were and not get confused. During an interview with the DON on 4/14/2026 at 10:45 AM , she reported staff are expected to knock/announce who they were as they entered a resident room. She reported not doing so would be an invasion of privacy and potential dignity issue. Record review of facility's policy and procedures Call Lights, Responding to, dated 5/5/2023, revealed staff knock on the patient or resident room door before entering to promote privacy and dignity.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #79 and Resident #28) of six residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #79 and #28's rooms were in a position that was accessible to the residents. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings included: Resident #79 Record review of Resident #79's Quarterly MDS Assessment, dated 03/07/2026, reflected a [AGE] year-old female, originally admitted to the facility on [DATE]. The resident had a BIMS score of 9 which indicated moderate cognitive impairment. Diagnoses included: Unspecified dementia (severe decrease in memory and intellectual functioning that can occur in the later stages of Parkinson's), Type II Diabetes (a condition where the body can't properly use sugar for energy, leading to high blood sugar and possible complications), and Hypertension (blood pressure is consistently too high, which can strain the heart and blood vessels). Resident #79 required extensive assistance for bed mobility, transfer, and toilet use. Review of Resident #79's Comprehensive Care Plan, dated 2/27/2026, reflected Resident #79 required the use of side rails (positioning bar) for turning and repositioning with an intervention of keeping the call light within reach. The plan also identified the resident as a fall risk with an intervention of keeping the call light within reach at all times. During an observation and interview on 4/12/2026 at 10:13 AM with Resident #79, she reported her incontinent brief was wet and needed changed. She reported she had not told anyone because she could not find her call button. Her call button was observed on a nightstand. Resident #79 stated she was not sure who put the call button there and could not reach it. During an interview with LVN A on 4/12/2026 at 10:17 AM, surveyor spoke to LVN A in the hallway and explained Resident #79 expressed she was needing changed and could not call for assistance because her call light was out of reach. LVN A stated she would send a CNA to help the Resident. LVN A was asked to accompany surveyor to Resident #79's room to see her call light placement. LVN A walked into the room and placed the call light on the resident's stomach and walked out. Resident #28 Record review of Resident #28's, admission MDS assessment dated [DATE], reflected a [AGE] year-old female, admitted to the facility on [DATE]. Resident 28's BIMS score was not completed on the assessment. Diagnoses included: senile degeneration of brain (the age-related, progressive, and irreversible loss of brain cells (neurons) and cognitive function) and essential primary hypertension (chronic high blood pressure that does not have a single, identifiable medical cause). Record review of Resident #28's Comprehensive Care Plan, dated 3/28/2026, reflected Resident #28 required assistance for bed mobility, toileting, transfers, and ambulation. During an observation and interview on 4/12/2026 at 10:04 AM, with Resident #28, she reported she needed her incontinence brief changed. She reported she had been waiting at least an hour. She reported she was unable to call anyone for help because she could not reach her call button. The resident's call button was observed on the floor on the side of the resident's bed, out of reach. Resident #28 said it fell off her bed earlier this morning. During an interview with LVN A on 4/12/2026 at 10:07 AM, she reported resident's use their call button if they need incontinence assistance. She stated everyone's call light should be within reach. She reported when she gave Resident #28's medications she had to pick up her call button from the floor. LVN A reported Resident #28 knocks the call button off her bed. LVN A picked the call button up and placed it back on Resident #28's bed within her reach. During an interview with the DON on 4/14/2026, she reported resident call light buttons are expected to be within reach. She stated everyone was responsible for that. She reported if a resident was unable to access their call button, they would not be able to call for assistance. Record review of facility's policy and procedures Call Lights, Responding to, dated 5/5/2023, revealed ensure the call light is placed within patient's/resident's reach.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a Comprehensive Assessment within 14 calendar days after admission, as well as at least once every 12 months, for one (Resident #28) of five residents reviewed for Comprehensive Assessments and timing. The facility failed to ensure a Comprehensive MDS Assessment for Resident #28 was completed within 14 days after her admission to the facility. This failure could place residents at risk for improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being.Findings included: Review of Resident #28's Face Sheet, dated 04/14/26, reflected she was a [AGE] year-old female, who was admitted to the facility on [DATE], with diagnoses including senile degeneration of brain (the age-related, progressive, and irreversible loss of brain cells (neurons) and cognitive function) and essential primary hypertension (chronic high blood pressure that does not have a single, identifiable medical cause). Review of Resident #28's electronic medical record on 04/14/26 reflected no evidence that an MDS Assessment had been completed. During an interview with the MDS Coordinator on 04/13/26 at 10:55 AM, she stated Resident #28 originally admitted to the facility as a respite resident on 03/27/26 and was only supposed to reside at the facility for four days. Resident #28's family then extended the respite stay twice (the second extension resulted in Resident #28 residing at the facility for more than 14 days). The MDS Coordinator stated she was not made aware that Resident #28's respite stay had been extended the second time, which was why her MDS Assessment was not completed within the required timeframe. The MDS Coordinator stated upon finding out that Resident #28's respite stay had been extended for the second time, she immediately initiated an admission MDS Assessment (which was still in the process of being completed) and notified admissions/administration to communicate with her any time a respite stay was extended. The MDS Coordinator stated the risk of MDS Assessments not being completed in the required timeframe was the potential for improper billing and funding. Review of the facility's Minimum Data Set (MDS) policy, dated 09/28/23, reflected, .Facilities are required to complete a comprehensive assessment of each resident within 14 calendar days after admission to the facility, when there is a significant change in the resident's status, and not less than once within 366 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676388	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion at Creekwood	2100 Cannon Dr Mansfield, TX 76063

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents was free of any significant medication error of 1 (Resident #1) of 5 residents reviewed for pharmacy services. The facility failed to ensure accurate transcription of Resident #1's prednisone orders (medication used to reduce inflammation and suppress the immune system, and severe illness flare-ups resulting in a missed medication dose. The failure resulted in a medication error and placed the resident at risk for adverse clinical outcomes, worsening the resident's condition or potential harm due to omission of the prescribed medication. Findings include: Record review of Resident #1's MDS Assessment, dated 03/04/26, reflected a [AGE] year-old male, admitted [DATE].No BIMS score was recorded, indicating no interview was conducted. No diagnosis was recorded in the MDS, resident was at the facility from 03/02/2026 - 03/04/2026. Record review of Resident #1's hospital records reflected he was admitted at the hospital from [DATE] to 03/02/2026, his diagnosis included Interstitial lung disease (lung disease that progresses and causes severe respiratory failure causes chronic inflammation and scarring (fibrosis) in lung tissue, impairing oxygen transfer and often leading to chronic or exertional hypoxia (low oxygen). Record review of Resident #1's active care plan, Baseline Care Plan, created 03/03/2026, reflected Resident #1 requires oxygen. Interventions included Administer oxygen as ordered, Observe for S/S of SOB, decreased perfusion (insufficient oxygen delivery to tissues). Report significant changes to the MD. Record review of Resident #1's discharge orders dated 03/02/2026 reflected: Take Prednisone (used to reduce inflammation and suppress the immune system, treating conditions like asthma, allergies, arthritis, skin diseases, and severe illness flare-ups) 16 tablets (80 milligrams total) by mouth daily for two days, then 14 tablets (70 milligrams total)daily for 14 days, then 12 tablets (60 milligrams total) daily for 14 days, then 10 tablets (50 milligrams total) daily for 14 days, then 8 tablets (40 milligrams total) daily for 14 days, then 6 tablets (30 milligrams total) daily for 14 days and then 4 tablets (20 milligrams total) daily for the 14 days, then 2 tablets (10 milligrams total) for 14 days, then 1 tablet (5 milligrams total) dealing for 14 days. Last taken 80 milligrams on March 2nd, 2026, at 8:24 AM. Start taking on March 3rd 2026. Record review of Resident #1's physician orders reflected prednisone was not transcribed on the physician orders and Medication Administration record on admission. Further review revealed the medication was not administered as ordered on 03/03/2026 resulting in a missed dose. Record review of Resident #1's March 2026 MAR reflected prednisone orders had start date of 03/04/2026. There was no prednisone orders dated 03/03/2026. Record review of Resident #1's records revealed the facility had completed medication error for the missed medication on 03/03/2026. During an interview on 04/13/2026 at 11:45 AM, the ADON- revealed Resident #1 was admitted on [DATE] at 4:30 PM. She stated the next day there was a note in her office from the nurse that admitted Resident #1 to please enter the prednisone order, but she did not see the note and there was no communication that it was her responsibility to enter the order. She stated the order was entered in PCC by another nurse manager. She stated Resident #1's FM spoke to her about medication but did not mention prednisone. She stated on 03/03/2026 she went to do rounds and Resident #1's FM informed her that he had not received his medication. She stated she had not audited his admission medication to see if there were any missing medications. She stated the risk to the resident was a missed dose and ineffective treatment. She stated she was suspended pending investigation and was still on suspension. During an interview on 04/13/2026 at 11:50 AM, LVN E revealed she was Resident #1's nurse when he admitted and the day he was transferred to the hospital. She stated LVN F assisted with entering medication in the computer. She stated she recalled the prednisone order was confusing and LVN F contacted the ADON to assist with entering the medications. She stated she was not aware the resident missed any medication because the medication aides administer medication and if there was medication that was missing the medication aide would notify her but on 03/03/2026 she was not (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified of Resident #1 missing medication. During an interview on 4/14/2026 at 12:10PM , LVN H revealed Resident #1 admitted on [DATE] in the evening. She stated LVN F left her note to assist in entering the prednisone orders. She stated she entered the orders on 03/03/2026 but populated on the MAR order the next day 3/04/2026. She stated she was not sure why he did not get the medication on 03/03/2026. She stated she was not aware that he missed the dose until she heard about it recently. She stated the ADONs audits all new admission orders to make sure all orders were transcribed. She stated the risk to the resident was medication error and up to death depending on the medication missed. During an interview on 04/13/2026 at 12:40 PM, the FM revealed Resident #1 was admitted to the facility on Monday 03/02/2026 around 4 PM. She stated on Tuesday 03/03/2026 he missed a dose of prednisone. She stated she was notified that there was confusion of how the orders were written from the hospital and the nurse needed to verify with the facility MD. She stated she spoke with the nurse and the ADON, and he got his prednisone on 03/04/2026. She stated the missed dose might have caused him to have a drop in oxygen level on 03/03/2026 when he was transferred to the hospital. During an interview on 04/14/2026 at 12:45 PM, LVN F revealed she assisted with entering Resident #1's admission orders. She stated order verification was done by LVN E. She stated she entered all the orders in but had an issue with the prednisone orders because it titrates and she did not know who to enter the order in PCC. She stated that she communicated with the ADON that she needed assistance with entering the prednisone orders. She stated she gave report to the oncoming night nurse she could not enter the prednisone orders and circled the orders that were not entered. She stated the risk of not transcribing the orders on admission could result in medication errors and depending on the medication it could have adverse effects on the residents to include hospitalization. During an interview on 04/14/2026 at 3:45 PM, the DON revealed Resident #1's prednisone order was not transcribed to the MAR on admission. She stated all new admission orders were audited and verified by the ADON the following morning after admission to make sure there was nothing omitted. She stated she was not sure why the audit was not done. She stated the ADON was suspended pending investigation. The DON stated the failure to accurately transcribe the order contributed to the missed dose and medication error. She stated all physician orders should be promptly and accurately transcribed to the MAR to ensure medications are administered as prescribed. During an interview on 04/14/2026 at 3:45PM, the MD revealed a chart review because Resident #1 was there for a short time and because of the missed dose. She stated the resident had been on a high dose of steroids and intravenous medication for over a month so it was not a new start for the steroids so it would have been sensitive to the medication. She stated he was readmitted for pneumonia which was not related to the missed dose. She stated when there was an issue with order clarification the nurses would call for a one-time order, so the resident does not miss the dose. She stated the risk of not transcribing admission orders was medication error and missed doses. Review of the facility's policy Medication Management Program Revised 1/ 5/2025 reflected the following: The facility's Medical Director will have an active role in the oversight of medication management, achieved in a variety of ways including medical record reviews, consultation, recommendations from pharmacy consultants and/or recommendations through the Quality Assurance and Performance Improvement process.2. Licensed Independent Practitioners, licensed nurses, consulting pharmacists, and pharmacy service providers collaborate and review medication orders to ensure medical and clinical necessity and appropriateness. The primary mechanism for this validation is an initial and ongoing medication reconciliation process.